CHAPTER XII

SUPPLEMENTAL SERVICES
HCPCS LEVEL II CODES A0000 – V9999
FOR
MEDICAID NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL

Fee schedules, relative value units, conversion factors, and/or related components aren't assigned by the AMA, aren't part of CPT, and the AMA isn't recommending their use. The AMA doesn't directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for the data contained or not contained herein.

CMS issues the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System.

Revision Date (Medicaid): 1/1/2026

Table of Contents

Chapter XII
Supplemental Services
HCPCS Level II Codes A0000 - V9999

A. Introduction

The principles of correct coding discussed in Chapter I apply to the Healthcare Common Procedure Coding System (HCPCS) Level II codes in the range A0000-V9999. Several general guidelines are repeated in this Chapter. However, those general guidelines from Chapter I not discussed in this Chapter are nonetheless applicable.

Physicians shall report the Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) code that describes the procedure performed to the greatest specificity possible. A HCPCS/CPT code shall be reported only if all services described by the code are performed. A physician shall not report multiple HCPCS/CPT codes if a single HCPCS/CPT code exists that describes the services performed. This type of unbundling is incorrect coding.

HCPCS/CPT codes include all services usually performed as part of the procedure as a standard of medical/surgical practice. A physician shall not separately report these services simply because HCPCS/CPT codes exist for them.

Specific issues unique to HCPCS Level II codes are clarified in this chapter.

The HCPCS Level II codes are alpha-numeric codes developed by the Centers for Medicare & Medicaid Services (CMS) as a complementary coding system to the *CPT Professional* codebook. These codes describe physician and non-physician services not included in the *CPT Professional* codebook, supplies, drugs, Durable Medical Equipment (DME), ambulance services, etc. The correct coding edits and policy statements that follow address those HCPCS Level II codes that are reported to Medicaid (MCD) fiscal agents.

The presence of a HCPCS/CPT code in a National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) edit, or of a Medically Unlikely Edit (MUE) value for a HCPCS/CPT code does not necessarily indicate that the code is covered by any or all state MCD programs.

In October 2012, CMS implemented a new NCCI methodology for MCD – i.e., NCCI PTP edits for DME.

The MCD NCCI program has also implemented additional edits in the original 5 methodologies that are unique to MCD NCCI – e.g., edits for codes that are noncovered or otherwise not separately payable by the Medicare (MCR) program (e.g., H, S and T series HCPCS Level II codes).

B. Evaluation & Management (E&M) Services

Physician services can be categorized as either major surgical procedures, minor surgical procedures, non-surgical procedures, or Evaluation & Management (E&M) services. This section summarizes some of the rules for reporting E&M services in relation to major surgical, minor surgical, and non-surgical procedures. Even in the absence of NCCI PTP edits, providers shall bill for their services following these rules.

The MCD NCCI program uses the same definition of major and minor surgery procedures as the MCR program.

- Major surgery – those codes with 090 Global Days in the "Medicare Physician Fee Schedule Database/Relative Value File"
- Minor surgery – those codes with 000 or 010 Global Days

The MCR designation of global days can be found on the Medicare/National Physician Fee Schedule/PFS Relative Value Files page of the CMS Medicare webpage.

Select the calendar year and the file name with highest alphabetical suffix – e.g., RVUxxD – for the most recent version of the fee schedule. In the zip file, select document "PPRRVU….xlsx" and refer to "Column O, Global Days."

An E&M service is separately reportable on the same date of service as a major or minor surgical procedure under limited circumstances.

If an E&M service is performed on the same date of service as a major surgical procedure to decide whether to perform this surgical procedure, the E&M service is separately reportable with modifier 57. Other preoperative E&M services on the same date of service as a major surgical procedure are included in the global package for the procedure and are not separately reportable. There are currently no NCCI PTP edits based on this rule.

In general, E&M services performed on the same date of service as a minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and shall not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform a minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. The NCCI program contains many, but not all, possible edits based on these principles.

For major and minor surgical procedures, postoperative E&M services related to recovery from the surgical procedure during the postoperative period are included in the global package as are E&M services related to complications of the surgery. Postoperative visits unrelated to the diagnosis for which the surgical procedure was performed, unless related to a complication of

surgery, may be reported separately on the same day as a surgical procedure with modifier 24 (Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period).

Many non-surgical procedures are performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work shall not be reported as a separate E&M code.

Other non-surgical procedures are not usually performed by a physician and have no physician work associated with them. A physician shall not report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most non-surgical procedures, the physician may, however, perform a significant and separately identifiable E&M service that is above and beyond the usual pre- and post-operative work of the procedure on the same date of service which may be reported by appending modifier 25 to the E&M code. This E&M service may be related to the same diagnosis necessitating performance of the non-surgical procedure but cannot include any work inherent in the non-surgical procedure, supervision of others performing the non-surgical procedure, or time for interpreting the result of the non-surgical procedure. Appending modifier 25 to a significant, separately identifiable E&M service when performed on the same date of service as a non-surgical procedure may be appropriate in some instances.

C. NCCI Procedure-to-Procedure (PTP) Edit Specific Issues

1. HCPCS code Q0091 (Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory) describes the services necessary to procure and transport a pap smear specimen to the laboratory. If an E&M service is performed at the same patient encounter solely for the purpose of performing a screening pap smear, the E&M service is not separately reportable. However, if a significant, separately identifiable E&M service is performed to evaluate other medical problems, the screening pap smear and the E&M service may be reported separately. Modifier 25 should be appended to the E&M CPT code indicating that a significant, separately identifiable E&M service was rendered.

2. HCPCS code G0101 (Cervical or vaginal cancer screening; pelvic and clinical breast examination) may be reported with E&M services under certain circumstances. If a covered reasonable and medically necessary E&M service requires breast and/or pelvic examination, HCPCS code G0101 shall not be additionally reported.

   However, if the covered reasonable and medically necessary E&M service and the screening service, G0101, are unrelated to one another, both HCPCS code G0101 and the E&M service may be reported appending modifier 25 to the E&M service CPT code. Use of modifier 25 indicates that the E&M service is significant and separately identifiable from the screening service, G0101.

3. Under the NCCI program, HCPCS code G0102 (Prostate cancer screening; digital rectal examination) is not separately payable with an E&M code (e.g., 99202-99499, G0463,

G0466-G0470, G0438, G0439).

4. Subsection deleted, January 1, 2024.

5. The HCPCS code A9512 (Technetium Tc-99m pertechnetate, diagnostic, per millicurie) describes a radiopharmaceutical used for nuclear medicine studies. Technetium Tc-99m pertechnetate is also a component of other Technetium Tc-99m radiopharmaceuticals with separate AXXXX codes. HCPCS code A9512 shall not be reported with other AXXXX radiopharmaceuticals containing Technetium Tc-99m for a single nuclear medicine study. However, if 2 separate nuclear medicine studies are performed on the same date of service, 1 with the radiopharmaceutical described by HCPCS code A9512 and 1 with another AXXXX radiopharmaceutical labeled with Technetium Tc-99m, both codes may be reported using an NCCI PTP-associated modifier. HCPCS codes A9500, A9540, and A9541 describe radiopharmaceuticals labeled with Technetium Tc-99m that may be used for separate nuclear medicine studies on the same date of service as a nuclear medicine study using the radiopharmaceutical described by HCPCS code A9512.

6. The NCCI program contains PTP edits that bundle some radiopharmaceutical codes into nuclear medicine procedure codes. In some situations where a patient has 2 nuclear medicine procedures performed on the same date of service, the radiopharmaceutical used for 1 nuclear medicine procedure may be incompatible with the second nuclear medicine procedure. In this circumstance, it may be appropriate to report the radiopharmaceutical with modifiers 59 or XE or XS.

7. HCPCS code A4220 describes a refill kit for an implantable pump. It shall not be reported separately with CPT codes 95990 (Refilling and maintenance of implantable pump…, spinal …or brain…when performed) or 95991 (Refilling and maintenance of implantable pump…, spinal …or brain…requiring physician or other qualified health care professional) since payment for these 2 CPT codes includes the refill kit.

   Similarly, HCPCS code A4220 shall not be reported separately with CPT codes 62369 (Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill) or 62370 (Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (requiring skill of a physician or other qualified health care professional)) since payment for these 2 CPT codes includes the refill kit.

8. HCPCS code E0781 describes an ambulatory infusion pump used by a patient for infusions outside the physician office or clinic. It is a misuse of this code to report the infusion pump typically used in the physician office or clinic.

9. HCPCS codes G0422 and G0423 (Intensive cardiac rehabilitation...per session) include the same services as the cardiac rehabilitation CPT codes 93797 and 93798 but at a greater frequency. Intensive cardiac rehabilitation may be reported with as many as 6

hourly sessions on a single date of service. Cardiac rehabilitation services include medical nutrition services to reduce cardiac disease risk factors. Medical nutrition therapy (CPT codes 97802-97804) shall not be reported separately for the same patient encounter. However, medical nutrition therapy services covered by a state MCD program and performed at a separate patient encounter on the same date of service may be reported separately. The state MCD covered medical nutrition service cannot be provided at the same patient encounter as the cardiac rehabilitation service.

Under the NCCI program, physical or occupational therapy services performed at the same patient encounter as cardiac rehabilitation services are included in the cardiac rehabilitation services and are not separately reportable. If physical therapy or occupational therapy services are performed at a separate, medically reasonable, and necessary patient encounter on the same date of service as cardiac rehabilitation services, both types of services may be reported using an NCCI PTP-associated modifier.

10. Pulmonary rehabilitation (HCPCS code G0424, CPT codes 94625, 94626) includes therapeutic services and all related monitoring services to improve respiratory function. (HCPCS code G0424 was deleted January 1, 2022).

    It requires measurement of patient outcome which includes, but is not limited to, pulmonary function testing (e.g., pulmonary stress testing (CPT codes 94618 and cardiopulmonary exercise testing 94621)). Pulmonary rehabilitation shall not be reported with HCPCS codes G0237 (Therapeutic procedures to increase strength or endurance of respiratory muscles… (includes monitoring)), G0238 (Therapeutic procedures to improve respiratory function… (includes monitoring)), or G0239 (Therapeutic procedures to improve respiratory function or increase strength…(includes monitoring)). The services are mutually exclusive. The procedures described by HCPCS codes G0237-G0239 include therapeutic procedures as well as all related monitoring services, the latter including, but not limited to, pulmonary function testing (e.g., pulmonary stress testing (CPT codes 94618 and cardiopulmonary exercise testing 94621)).

    Under the NCCI program, physical or occupational therapy services performed at the same patient encounter as pulmonary rehabilitation services are included in the pulmonary rehabilitation services and are not separately reportable. If physical therapy or occupational therapy services are performed at a separate, medically reasonable, and necessary patient encounter on the same date of service as pulmonary rehabilitation services, both types of services may be reported using an NCCI PTP-associated modifier. Similarly, physical, and occupational therapy services are not separately reportable with therapeutic pulmonary procedures for the same patient encounter.

    Medical nutrition therapy services (CPT codes 97802-97804) performed at the same patient encounter as a pulmonary rehabilitation or pulmonary therapeutic service are included in the pulmonary rehabilitation or pulmonary therapeutic service and are not separately reportable. If a physician provides a state MCD covered medical nutrition service to a beneficiary on the same date of service as a pulmonary rehabilitation or pulmonary therapeutic service but at a separate patient encounter, the medical nutrition

therapy service may be separately reportable with an NCCI PTP-associated modifier. The state MCD covered medical nutrition service cannot be reported at the same patient encounter as the pulmonary rehabilitation or pulmonary therapeutic service.

11. Presumptive drug testing may be reported with CPT codes 80305-80307. These codes differ based on the level of complexity of the testing methodology. Only one code from this code range may be reported per date of service.

    Definitive drug testing may be reported with HCPCS codes G0480-G0483 or CPT codes 80320-80377 or 83992. The G codes differ based on the number of drug classes including metabolites tested. HCPCS code G0659 defining a different type of definitive drug testing was added. Only one definitive drug testing HCPCS code may be reported per date of service.

12. See Section M, Subsection 8, for Telehealth Services.

13. Blood products are described by HCPCS Level II P codes. If a P code describes an irradiated blood product, CPT code 86945 (Irradiation of blood product, each unit) should not be reported separately since the P code includes irradiation of the blood product. If a P code describes a CMV negative blood product, CPT codes 86644 and/or 86645 (CMV antibody) should not be reported separately for that blood product since the P code includes the CMV antibody testing. If a P code describes a deglycerolized blood product, CPT codes 86930 (Frozen blood, each unit; freezing (includes preparation)), 86931 (Frozen blood, each unit; thawing), and/or 86932 (Frozen blood, each unit; freezing (includes preparation) and thawing) should not be reported separately since the P code includes the freezing and thawing processes.

    If a P code describes a pooled blood product, CPT code 86965 (Pooling of platelets or other blood products) shall not be reported separately since the P code includes the pooling of the blood products. If the P code describes a “frozen” plasma product, CPT code 86927 (Fresh frozen plasma, thawing, each unit) shall not be reported separately since the P code includes the thawing process.

14. HCPCS codes G0396 and G0397 describe alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services. These codes shall not be reported separately with an E&M, psychiatric diagnostic, or psychotherapy service code for the same work/time. If the E&M, psychiatric diagnostic, or psychotherapy service would normally include assessment and/or intervention of alcohol or substance abuse based on the patient’s clinical presentation, HCPCS G0396 or G0397 shall not be additionally reported. If a physician reports either of these G codes with an E&M, psychiatric diagnostic, or psychotherapy code using an NCCI PTP-associated modifier, the physician is certifying that the G code service is a distinct and separate service performed during a separate time period (not necessarily a separate patient encounter) than the E&M, psychiatric diagnostic, or psychotherapy service and is a service that is not included in the E&M, psychiatric diagnostic, or psychotherapy service based on the clinical reason for the E&M, psychiatric diagnostic, or psychotherapy service.

CPT codes 99408 and 99409 describe services which are similar to those described by HCPCS codes G0396 and G0397 but are "screening services." Where CPT codes 99408 and 99409 are covered by state MCD programs, the policies explained in the previous paragraph for G0396/G0397 also apply to 99408/99409. Codes 99408/99409 shall not be reported in addition to codes G0396/G0397.

The same principles apply to separate reporting of E&M services with other screening, intervention, or counseling service HCPCS Level II codes (e.g., G0442 (Annual alcohol misuse screening, 5 to 15 minutes), G0443 (Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes), and G0444 (Annual depression screening, 5 to 15 minutes). If an E&M, psychiatric diagnostic, or psychotherapy service is related to a problem which would normally require evaluation and management duplicative of the HCPCS Level II code, the HCPCS Level II code is not separately reportable.

For example, if a patient presents with symptoms suggestive of depression, the provider should not report G0444 in addition to the E&M, psychiatric diagnostic, or psychotherapy service code. The time and work effort devoted to the HCPCS code screening, intervention, or counseling service must be distinct and separate from the time and work of the E&M, psychiatric diagnostic, or psychotherapy service. Both services may occur at the same patient encounter.

15. HCPCS code G0269 describes placement of an occlusive device into a venous or arterial access site after an open or percutaneous vascular procedure. Payment for this service is included in the payment for the vascular procedure.

16. HCPCS code V2790 (Amniotic membrane for surgical reconstruction, per procedure) shall not be reported separately with CPT codes 65778 (Placement of amniotic membrane on the ocular surface; without sutures) or 65779 (Placement of amniotic membrane on the ocular surface; single layer, sutured) since payment for these 2 CPT codes includes the amniotic membrane.

17. Subsection deleted, January 1, 2025.

D. Wheelchairs and Related Items

Codes for wheelchair bases describe complete products. Codes for wheelchair options, accessories, or seating systems describe items that can either be added to a complete wheelchair base or substituted for an existing component on a wheelchair base.

The following principles apply to items provided on the same date of service:

1. Two different wheelchair bases shall not be reported separately.

2. The code for a wheelchair option or accessory must be compatible with the type of wheelchair that is provided. For example, a sip and puff drive control interface (e.g., HCPCS code E2325) shall not be reported with a Group 1 power wheelchair (e.g.,

HCPCS code K0813-K0816).

3. The code for a wheelchair repair or replacement part shall not be reported at the time of initial issue of a wheelchair base. For example, a replacement motor (e.g., HCPCS code E2368) shall not be reported with a power wheelchair base.

4. A wheelchair option or accessory shall not be reported separately if it is included in the payment for the wheelchair base. For example, a complete footrest assembly (e.g., HCPCS code K0045) shall not be reported with a wheelchair base.

5. A separate code for a wheelchair seat cushion shall not be reported with any power wheelchair that has captain's chair style seating, with any power operated vehicle (POV), or with a rollabout chair or transport chair.

6. Two codes for items in the same general category of wheelchair options, accessories, or seating systems shall not be reported separately. For example, different types of power seating systems (e.g., HCPCS codes E1002-E1008) shall not be reported separately.

7. A wheelchair option, accessory, or seating component shall not be reported separately if it is included in the payment for another item. For example, a solid seat insert (e.g., HCPCS code E0992) shall not be reported with a wheelchair seat cushion (e.g., HCPCS codes E2601-E2610, E2622-E2625).

E. Other Durable Medical Equipment (DME)

The following principles apply to items provided on the same date of service:

1. Different types of similar equipment shall not be reported separately. For example, a wheeled walker (e.g., HCPCS codes E0141, E0143) shall not be reported with a non-wheeled walker (e.g., HCPCS codes E0130, E0135).

2. Codes that describe items that are components of other codes shall not be reported separately. For example, oxygen contents (e.g., HCPCS codes E0441, E0442) shall not be reported with rented oxygen equipment (e.g., HCPCS codes E0424, E0439).

3. Accessories must be compatible with the specific type of equipment provided. For example, a replacement interface for a nasal mask used with a continuous positive airway pressure (CPAP) device (e.g., HCPCS code A7032) shall not be reported with a full-face mask used with a CPAP device (e.g., HCPCS code A7030).

F. Spinal and Limb Orthoses

An orthosis base code describes a complete orthosis. An orthosis addition code describes items that can either be added to a complete orthosis or substituted for an existing component of an orthosis.

The following principles apply to items provided on the same date of service:

1. Two different orthosis base codes for the same anatomical region shall not be reported for the same limb. For example, only one hand finger orthosis (HFO) base code (e.g., HCPCS codes L3912, L3913, L3921, L3923, L3929) shall be reported for the same limb.

2. Orthoses from different anatomical regions that overlap cannot be worn at the same time. For example, a code for a unilateral hip knee ankle foot orthosis (HKAFO) (e.g., HCPCS codes L2070-L2090) shall not be reported with an ankle foot orthosis (AFO) (e.g., HCPCS codes L1900-L1990) for the same leg.

3. Most orthoses from adjacent anatomical regions cannot be worn at the same time. For example, a code for a hip orthosis (HO) (e.g., HCPCS code L1686) shall not be reported with a KAFO (e.g., HCPCS codes L2000-L2038) for the same leg because the HO extends to the mid-thigh and the KAFO begins at the mid-thigh and therefore both cannot be worn at the same time.

4. Addition codes can only be used with certain types of base orthosis codes. For example, a code that describes an "addition to TLSO" (e.g., HCPCS codes L1210-L1290) shall not be reported with a lumbar sacral orthosis (LSO) (e.g., HCPCS codes L0628-L0640).

G. Limb Prostheses

A prosthesis base code describes a complete prosthesis. A prosthesis addition code describes items that can either be added to a complete prosthesis or substituted for an existing component of a prosthesis.

The following principles apply to items provided on the same date of service:

1. Only one complete prosthesis shall be reported for the same limb. For example, an above knee (AK) prosthesis (e.g., HCPCS codes L5200-L5230) and a below knee (BK) prosthesis (e.g., HCPCS codes L5100, L5105) shall not be reported for the same limb.

2. Only one component in the same category (e.g., an electric hand [e.g., HCPCS codes L6880, L7007, L7008] or a non-electric terminal device [e.g., HCPCS codes L6703-L6722] for an upper limb prosthesis) shall be reported for the same limb.

3. Codes that represent components of other codes shall not be reported for the same limb. For example, batteries (e.g., HCPCS codes L7360, L7364, L7367) and a charger (e.g., HCPCS codes L7362, L7366, L7368) are included in electrical components (e.g., HCPCS codes L7007-L7259) at initial issue and shall not be reported separately.

4. Components for different amputation levels (e.g., an above knee [AK] socket [e.g., HCPCS code L5631] and a below knee [BK] socket [e.g., HCPCS code L5645]) shall not be reported for the same limb.

5. Addition codes that do not match the base prosthesis code shall not be reported. For example, a BK addition (e.g., HCPCS code L5655) shall not be reported with an AK base prosthesis (e.g., HCPCS codes L5200-L5230) for the same leg.

6. Certain addition codes should not be reported with preparatory or immediate prosthesis base codes. For example, an electric hand (e.g., HCPCS code L7007) shall not be reported with a preparatory prosthesis (e.g., HCPCS codes L6584-L6586).

H. Orthopedic Shoes and Inserts

The following principles apply to items provided on the same date of service:

1. Different types of foot orthotics or different types of shoes shall not be reported for the same foot. For example, a silicone gel insert (e.g., HCPCS code L3003) and a Plastazote insert (e.g., HCPCS code L3002) shall not be reported for the same foot.

2. Addition codes which are standard features of shoes shall not be reported separately. For example, a new standard rubber heel (e.g., HCPCS code L3460) shall not be reported with a shoe (e.g., HCPCS codes L3215-L3222) for the same foot.

3. Different shoe modifications of the same type (e.g., 2 different sole wedges [e.g., HCPCS codes L3360 and L3370]) shall not be reported for a shoe for the same foot.

I. Hearing Aids

The following principles apply to items provided on the same date of service:

1. Only one type of binaural hearing aid may be reported. For example, a behind the ear digital binaural hearing aid (e.g., HCPCS code V5261) shall not be reported with a behind the ear digitally programmable binaural hearing aid (e.g., HCPCS code V5253).

2. Only one type of monaural hearing device may be reported for the same ear. For example, a digital monaural behind the ear hearing aid (e.g., HCPCS code V5257) shall not be reported with a digital monaural in the ear hearing aid (e.g., HCPCS code V5256) for the same ear.

3. A binaural behind the ear hearing aid (e.g., HCPCS code V5140) shall not be reported with a monaural hearing aid (e.g., HCPCS code V5256).

4. Similar assistive listening devices shall not be reported separately. For example, a fm/dm system assistive listening device with a loop induction receiver (e.g., HCPCS code V5283) shall not be reported with an assistive device with a Bluetooth receiver (e.g., HCPCS code V5286).

5. Codes that are components of other codes should not be reported separately. For example, a transmitter microphone (e.g., HCPCS code V5290) shall not be reported with

a binaural fm/dm system assistive listening device (e.g., HCPCS code V5282).

J. Eyeglasses

The following principles apply to items provided on the same date of service:

1. Different types of similar items shall not be reported for the same eye. For example, a plano to +/- 4.00d bifocal lens (e.g., HCPCS code V2200) shall not be reported with a similar lens with 0.12-2.00 cylinder (e.g., HCPCS code V2203) for the same eye.

2. Certain addition codes are incompatible with specific lens codes. For example, bifocal segment width over 28 mm (e.g., HCPCS code V2219) shall not be reported with a trifocal lens (e.g., HCPCS codes V2300-V2399) for the same eye.

3. Different types of similar features (e.g., HCPCS codes V2710 and V2715 for prism add-on) shall not be reported for the same eye.

K. Therapeutic Shoes for Diabetics

The following principles apply to items provided on the same date of service:

1. Only one pair of shoes shall be reported on the same date of service.

2. Inserts and modifications for therapeutic shoes for diabetics (HCPCS codes A5500, A5501) shall be reported with HCPCS codes A5503-A5513. They shall not be reported with L3xxx codes for orthopedic shoes.

3. Inserts and modifications for orthopedic shoes (HCPCS codes L3201-L3253) should be reported with HCPCS codes L3000-L3170 and L3254-L3649. They shall not be reported with A55xx codes for diabetic shoes.

L. Urological Supplies

The following principles apply to items provided on the same date of service:

1. Only one type of indwelling catheter, intermittent catheter, or external catheter shall be reported on the same date of service.

2. Intermittent catheters shall not be reported with supplies that are used with indwelling or exdwelling catheters.

3. Exdwelling catheters shall not be reported with supplies that are used with indwelling catheters.

M. Medically Unlikely Edits (MUEs)

1. Medically Unlikely Edits (MUEs) are described in Chapter I, Section V.

2. Providers should be cautious about reporting services on multiple lines of a claim using modifiers to bypass MUEs. The MUE values are set so that such occurrences should be uncommon. If a provider does this frequently for any HCPCS/CPT code, the provider may be coding units of service (UOS) incorrectly. The provider may consider contacting their national health care organization or the national medical/surgical society whose members commonly perform the procedure to clarify the correct reporting of UOS.

3. The MUE values of HCPCS Level II codes for discontinued drugs are generally "0."

4. The MUE value of HCPCS Level II codes describing compounded inhalation drugs is "0" because compounded drugs are generally not FDA approved.

5. HCPCS code J0171 (Injection, adrenalin, epinephrine, 0.1 mg) may be reported incorrectly. A 1 ml ampule of adrenalin/ epinephrine contains 1.0 mg of adrenalin/epinephrine in a 1:1,000 solution. However, a 10 ml prefilled syringe with a 1:10,000 solution of adrenalin/epinephrine also contains only 1.0 mg of adrenalin/epinephrine. Thus, a physician must recognize that 10 UOS for HCPCS code J0171 corresponds to a 1 ml ampule or 10 ml of a prefilled syringe (1:10,000 (0.1 mg/ml) solution). (HCPCS code J0171 was deleted July 1, 2025.)

6. There may be multiple HCPCS Level II codes describing certain drugs. For example, HCPCS code J1094 (Injection, dexamethasone acetate, 1 mg) is no longer manufactured and has an MUE value of "0". HCPCS code J1100 (Injection, dexamethasone sodium phosphate, 1 mg) is available and has an MUE of 120. When billing for drugs, providers/suppliers should be careful to report the correct formulation with the correct HCPCS code. (HCPCS code J1094 was deleted April 1, 2025.)

7. Based on the code descriptor, HCPCS code J3471 (Injection, hyaluronidase, ovine, preservative free, per 1 USP unit (up to 999 USP units)), the physician may report HCPCS code J3471 on more than one line of a claim appending modifier 59 or XU to additional claim lines.

8. HCPCS codes G0406-G0408 describe follow-up inpatient consultation services via telehealth and HCPCS codes G0425-G0427 describe emergency or initial inpatient telehealth consultation services via telehealth. These codes shall not be reported by a practitioner on the same date of service that the practitioner reports a face-to-face E&M code. These codes are used to report telehealth services that if performed with the patient physically present would be reported with corresponding CPT codes.

   Since follow-up inpatient consultation services with a patient present are reported using per diem CPT codes 99231-99233, HCPCS codes G0406-G0408 may only be reported with a single unit of service per day.

Since initial inpatient consultation services with a patient present are reported using per diem CPT codes 99231-99233, HCPCS codes G0425-G0427 may only be reported with a single unit of service per day when reporting inpatient telehealth consultation services. However, if HCPCS codes G0425-G0427 are used to report emergency department services, reporting rules are comparable to CPT codes 99281-99285.

9. If a HCPCS Level II drug code descriptor defines the unit of service as "per dose," only one unit of service may be reported per drug administration procedure even if more than the usual amount of drug is administered. For example, HCPCS code J7321 (Hyaluronan or derivative, Hyalgan, Supartz, or Visco-3, for intra-articular injection, per dose) describes a drug that may be injected into the knee joint. Only one unit of service may be reported for injection of the drug into each knee joint even if the amount of injected drug exceeds the usual amount of drug injected.

10. Presumptive drug testing may be reported with CPT codes 80305-80307. These codes differ based on the level of complexity of the testing methodology. Only one code from this code range may be reported per date of service.

    Definitive drug testing may be reported with HCPCS codes G0480-G0483 or CPT codes 80320-80377 or 83992. The G codes differ based on the number of drug classes including metabolites tested. HCPCS codes G0480-G0483 are reported "per day" and shall not be reported with more than one unit of service per day. Codes 80320-80377 or 83992 shall not be reported on the same date of service as codes G0480-G0483. Definitive drug testing HCPCS code G0659 is reported "per day" and shall not be reported with more than one unit per day.

11. HCPCS codes Q9951 and Q9965-Q9967 describe low osmolar contrast material with different iodine concentrations. The appropriate code to report is based on the iodine concentration in the contrast material administered. HCPCS code Q9951 (Low osmolar contrast material, 400 or greater mg/ml iodine concentration, per ml) is often incorrectly reported for low osmolar contrast material products with lower iodine concentrations. Similarly, HCPCS codes Q9958-Q9964 describe high osmolar contrast material with different iodine concentrations. The appropriate code to report is based on the iodine concentration in the contrast material administered.

12. MUE values for surgical procedures that may be performed bilaterally are based on the NCCI coding principle that a bilateral surgical procedure should be reported on one line of a claim with modifier 50 and one unit of service unless the code descriptor defines the procedure as "bilateral." If the code descriptor defines the procedure as a "bilateral" procedure, it shall be reported with one unit of service without modifier 50. This coding principle does not apply to non-surgical diagnostic and therapeutic procedures.

13. For H, S, and T series HCPCS Level II codes, MUE values are based on the description of the unit of service in the code descriptor (e.g., per hour, per diem). If an individual state has defined the unit of service for a HCPCS Level II code differently (e.g., per 15 minutes instead of per diem), the state may request permission from CMS to deactivate

that MUE.

14. If the unit of service for evaluation and/or management service is not defined in a H, S, or T series HCPCS Level II code descriptor (e.g., code H1000 – Prenatal care, at-risk assessment), the MUE value is usually based on a unit of service per visit. If an individual state has defined the unit of service for a HCPCS Level II code differently (e.g., per hour), the state may request permission from CMS to deactivate that MUE.

15. When providing items for arms, legs, or other paired organs, the appropriate anatomical HCPCS modifier (e.g., RT – right side, LT – left side) should be appended to the HCPCS Level II code.

16. HCPCS code K0462 (Temporary replacement for patient owned equipment being repaired, any type) may be reported with one unit of service for each item of patient owned equipment that is being repaired. Component parts of a patient owned piece of equipment being repaired shall not be reported separately. For example, if a patient owned CPAP blower requires repair, the supplier may report one unit of service for K0462. The supplier shall not report an additional unit of service for an integral humidifier even if it also requires repair. The supplier shall not report an additional unit of service for a detachable humidifier unless it also requires repair at the same time.

17. Generally, only one unit of service for an item of DME (e.g., oxygen concentrator, wheelchair base) may be paid on a single date of service. Payment for backup or duplicate DME is not generally allowed. More than one unit of service may be paid on a single date of service for accessories and supplies related to DME when appropriate. Prosthetics and orthotics may also be paid with more than one unit of service on a single date of service if the items are for different limbs.

18. HCPCS code P9604 describes a prorated, one-way travel allowance for collection of medically necessary laboratory specimen (s) drawn from a home bound or nursing home bound patient. A round trip should be reported with modifier LR and 1 unit of service rather than 2 UOS. The reported UOS should be prorated for multiple patients drawn at the same address and for stops at the homes of MCD and non-MCD patients.

19. HCPCS code G9157 (Transesophageal doppler measurement of cardiac output (including probe placement, image acquisition, and interpretation per course of treatment) for monitoring purposes) describes a diagnostic procedure reportable only for ventilated patients in the Intensive Care Unit or operative patients with a need for intra-operative fluid optimization. Reporting this code is limited to an inpatient hospital place of service. HCPCS code G9157 shall be reporter no more than once per course of treatment.

N. General Policy Statements

1. In this manual many policies are described using the term “physician.” Unless indicated differently the use of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, or providers eligible to bill the relevant HCPCS/CPT codes

pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and MCD rules. In some sections of this manual, the term "physician" would not include some of these entities because specific rules do not apply to them.

2. The MUE values and NCCI PTP edits are based on services provided by the same physician to the same beneficiary on the same date of service. Physicians shall not inconvenience beneficiaries nor increase risks to beneficiaries by performing services on different dates of service to avoid MUE or NCCI PTP edits.

3. In 2010, the *CPT Professional* codebook modified the numbering of codes so that the sequence of codes as they appear in the *CPT Professional* codebook does not necessarily correspond to a sequential numbering of codes. In the *Medicaid NCCI Policy Manual*, use of a numerical range of codes reflects all codes that numerically fall within the range regardless of their sequential order in the *CPT Professional* codebook.

4. With few exceptions the payment for a surgical procedure includes payment for dressings, supplies, and local anesthesia. These items are not separately reportable under their own HCPCS/CPT codes. Wound closures using adhesive strips or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service. Under limited circumstances wound closure using tissue adhesive may be reported separately. If a practitioner uses a tissue adhesive alone for a wound closure, it may be reported separately with HCPCS code G0168 (Wound closure utilizing tissue adhesive(s) only). If a practitioner uses tissue adhesive in addition to staples or sutures to close a wound, HCPCS code G0168 is not separately reportable but is included in the tissue repair. Facilities may report wound closure using sutures, staples, or tissue adhesives, singly or in combination with each other, with the appropriate CPT code in the "Repair (Closure)" section of the *CPT Professional* codebook.

5. With the exception of moderate conscious sedation (see below), the NCCI program does not allow separate reporting of anesthesia for a medical or surgical procedure when it is provided by the physician performing the procedure. The physician shall not report CPT codes 00100-01999, 62320-62327, or 64400-64530 for anesthesia for a procedure. Additionally, the physician shall not unbundle the anesthesia procedure and report component codes individually. For example, introduction of a needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), drug administration (e.g., CPT codes 96360-96379) or cardiac assessment (e.g., CPT codes 93000-93010, 93040-93042) shall not be reported when these procedures are related to the delivery of an anesthetic agent.

   The NCCI program generally allows separate reporting for moderate conscious sedation services (CPT codes 99151-99153) when it is provided by the same physician performing a medical or surgical procedure except when the anesthesia service is bundled into the procedure, e.g., radiation treatment management.

Under the NCCI program, drug administration services related to operative procedures are included in the associated procedural HCPCS/CPT codes. Examples of such drug administration services include, but are not limited to, anesthesia (local or other), hydration, and medications such as anxiolytics or antibiotics. Providers shall not report CPT codes 96360-96379 for these services.

Under the NCCI program, postoperative pain management is not separately reportable when it is provided by the physician performing an operative procedure. CPT codes 36000, 36410, 62320-62327, 64400-64489, and 96360-96379 describe some services that may be used for postoperative pain management. The services described by these codes may be reported by the physician performing the operative procedure only if unrelated to the postoperative pain management, the operative procedure, or anesthesia for the procedure.

If a physician performing an operative procedure provides a drug administration service (e.g., CPT codes 96360-96379) unrelated to anesthesia, intra-operative care, or post-procedure pain management, the drug administration service (e.g., CPT codes 96360-96379) may be reported with an NCCI PTP-associated modifier if performed in a non-facility site of service.

6. The global package includes insertion of urinary catheters. CPT codes 51701-51703 (insertion of bladder catheters) shall not be reported with any surgical procedure.

7. Wound repair CPT codes 12001-13153 shall not be reported separately to describe closure of incisions for surgical procedures. Closure/repair of a surgical incision is included in the global package. Simple, intermediate, and complex wound repair codes may be reported with Mohs surgery (CPT codes 17311-17315). Intermediate and complex repair codes may be reported with excision of benign lesions (CPT codes 11401-11406, 11421-11426, 11441-11471) and excision of malignant lesions (CPT codes 11600-11646). Wound repair codes (CPT codes 12001-13153) shall not be reported with excisions of benign lesions with an excised diameter of 0.5 cm or less (CPT codes 11400, 11420, 11440).

8. Control of bleeding during an operative procedure is an integral component of a surgical procedure and is not separately reportable. Postoperative control of bleeding not requiring return to the operating room is included in the global package and is not separately reportable. However, control of bleeding requiring return to the operating room in the postoperative period is separately reportable using modifier 78.

9. For more information regarding biopsies, see Chapter I, Section A, Introduction.

10. Most NCCI PTP edits for codes describing procedures that may be performed on bilateral organs or structures (e.g., arms, eyes, kidneys, lungs) allow use of NCCI PTP-associated modifiers (Correct Coding Modifier Indicator (CCMI) of "1") because the 2 codes of the code pair edit may be reported if the 2 procedures are performed on contralateral organs or structures. Most of these code pairs should not be reported with NCCI PTP-associated

modifiers when the corresponding procedures are performed on the ipsilateral organ or structure unless there is a specific coding rationale to bypass the edit. The existence of the NCCI PTP edit indicates that the 2 codes generally should not be reported together unless the 2 corresponding procedures are performed at 2 separate patient encounters or 2 separate anatomic sites. However, if the corresponding procedures are performed at the same patient encounter and in contiguous structures, NCCI PTP-associated modifiers should generally not be used.

11. If fluoroscopy is performed during an endoscopic procedure, it is integral to the procedure. This principle applies to all endoscopic procedures including, but not limited to, laparoscopy, hysteroscopy, thoracoscopy, arthroscopy, esophagoscopy, colonoscopy, other GI endoscopy, laryngoscopy, bronchoscopy, and cystourethroscopy.

12. If the code descriptor for a HCPCS/CPT code, *CPT Professional* codebook instruction for a code, or MCD NCCI policy for a code indicates that the procedure includes radiologic guidance, a physician shall not separately report a HCPCS/CPT code for radiologic guidance including, but not limited to, fluoroscopy, ultrasound, computed tomography (CT), or magnetic resonance imaging (MRI) codes. If the physician performs an additional procedure on the same date of service for which a radiologic guidance or imaging code may be separately reported, the radiologic guidance or imaging code appropriate for that additional procedure may be reported separately with an NCCI PTP-associated modifier if appropriate.

13. CPT code 36591 describes "collection of blood specimen from a completely implantable venous access device." CPT code 36592 describes "collection of blood specimen using an established central or peripheral catheter, venous, not otherwise specified." These codes shall not be reported with any service other than a laboratory service. However, these codes may be reported if the only non-laboratory service performed is the collection of a blood specimen by one of these methods.

14. CPT code 96523 describes "irrigation of implanted venous access…" This code may be reported only if no other service is reported for the patient encounter.